SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American National Life Insurance Company of Texas

Product Name: Questionnaires	SERFF Tr Num: AMNA-127137079	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 48729
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: QUESTIONNAIRES	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Tyra Reed, Tobie Brink	Disposition Date: 05/13/2011
	Date Submitted: 05/10/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Tobie Brink
Filing Description:
May 9, 2011
Arkansas Insurance Department
Compliance - Life and Health
1200 West Third Street
Little Rock AR 72201-1904

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Texas is a member of the Interstate Insurance Product Regulation Commission
Market Type: Individual
Individual Market Type:
Filing Status Changed: 05/13/2011
State Status Changed: 05/13/2011
Created By: Tyra Reed
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

American National Life Insurance Company of Texas (NAIC: 71773 FEIN: 75-1016594) Filing of Supplemental Questionnaire forms:

ANL-MIL-AR Military Status Questionnaire
ANL-FOR-AR Foreign Travel Questionnaire
ANL-DIA-AR Diabetic Questionnaire
ANL-EPI-AR Epilepsy/Seizure Questionnaire
ANL-SCU-AR Scuba Diving Questionnaire
ANL-RES-AR Respiratory Questionnaire
ANL-BLO-AR Blood Pressure Questionnaire
ANL-DRU-AR Drug Use Questionnaire
ANL-ALC-AR Alcohol Use Questionnaire
ANL-CUP-AR Check-up Questionnaire
ANL-AVI-AR Aviation Questionnaire
ANL-MOT-AR Motor Sports Questionnaire
ANL-RAC-AR Racing Questionnaire
ANL-CPA-AR Chest Pain Questionnaire
ANL-SPO-AR Sports Amusement or Aviation
ANL-DIS-AR Disabled Applicant Questionnaire
ANL-ABP Additional Beneficiary Page

SERFF Tracking Number AMNA- 127137079
Company Tracking Number: QUESTIONNAIRES

Dear Sir or Madam,

Please find the above referenced questionnaires attached for your department's review and approval. These are new forms and are not intended to replace any previously approved forms.

These forms will be used in conjunction with the application for life insurance ANL-3409AR approved under SERFF Tracking Number AMNA-127025091.

Within the application, there is medical history and other similar type questions used to assist us in determining the insurability and risk class of the applicant. For some of these questions, a 'yes' answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a 'yes' answer, the underwriter can

request the completion of a supplemental questionnaire at their discretion, usually based on findings in a report or medical examination on the applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

Form ANL-ABP is the Application - Additional Beneficiary Page for Life Insurance.
This form may be used when multiple beneficiaries are named and additional space is needed or the applicant may have special instructions regarding the designation of a beneficiary(ies). In lieu of being restricted by the space provided on the application, this form may be completed and submitted with the application. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Additional information/supporting documentation included in this submission is as follows:
-Statement of Variability for the form
-Certificate of Readability
-Payment of the required filing fee in the amount of $1700.00 has been submitted via EFT
-Any requirement for a third party authorization has been bypassed, as this is not a third-party filing

Company and Contact

Filing Contact Information

Tyra Reed, Policy Analyst	tyra.reed@anico.com
One Moody Plaza	409-763-1112 [Phone] 5222 [Ext]
Product Development--14th Floor	409-766-6933 [FAX]
Galveston, TX 77550	

Filing Company Information

American National Life Insurance Company of Texas	CoCode: 71773	State of Domicile: Texas
One Moody Plaza	Group Code: 408	Company Type: Life, Health, Annuity
Galveston, TX 77550	Group Name:	State ID Number:
(409) 763-4661 ext. 5222[Phone]	FEIN Number: 75-1016594	

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,700.00
Retaliatory?	Yes
Fee Explanation:	Domicile fee is $1700.00 ($100 per form) (Texas).
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American National Life Insurance Company of Texas	$1,700.00	05/10/2011	47416891

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/13/2011	05/13/2011

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/13/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Variability		Yes
Form	Military Status Questionnaire		Yes
Form	Foreign Travel Questionnaire		Yes
Form	Diabetic Questionnaire		Yes
Form	Epilepsy/Seizure Questionnaire		Yes
Form	Scuba Diving Questionnaire		Yes
Form	Respiratory Questionnaire		Yes
Form	Blood Pressure Questionnaire		Yes
Form	Drug Use Questionnaire		Yes
Form	Alcohol Use Questionnaire		Yes
Form	Check-Up Questionnaire		Yes
Form	Aviation Questionnaire		Yes
Form	Motor Sports Questionnaire		Yes
Form	Racing Questionnaire		Yes
Form	Chest Pain Questionnaire		Yes
Form	Sports Amusement and Aviation Questionnaire		Yes
Form	Disabled Applicant Questionnaire		Yes
Form	Additional Beneficiary Page		Yes

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ANL-MIL-AR	Application/ Enrollment Questionnaire Form	Military Status	Initial		66.500	ANL-MIL-AR.pdf
	ANL-FOR-AR	Application/ Enrollment Questionnaire Form	Foreign Travel	Initial		57.900	ANL-FOR AR.pdf
	ANL-DIA-AR	Application/ Enrollment Questionnaire Form	Diabetic	Initial		61.200	ANL-DIA-AR.pdf
	ANL-EPI-AR	Application/ Enrollment Questionnaire Form	Epilepsy/Seizure	Initial		61.500	ANL-EPI-AR.pdf
	ANL-SCU-AR	Application/ Enrollment Questionnaire Form	Scuba Diving	Initial		57.900	ANL-SCU-AR.pdf
	ANL-RES-AR	Application/ Enrollment Questionnaire Form	Respiratory	Initial		62.100	ANL-RES-AR.pdf
	ANL-BLO-AR	Application/ Enrollment Questionnaire Form	Blood Pressure	Initial		60.300	ANL-BLO-AR.pdf
	ANL-DRU-AR	Application/ Enrollment Questionnaire Form	Drug Use	Initial		55.900	ANL-DRU-AR.pdf
	ANL-ALC-AR	Application/ Enrollment Questionnaire Form	Alcohol Use	Initial		52.100	ANL-ALC-AR.pdf
	ANL-CUP-AR	Application/ Enrollment Questionnaire	Check-Up	Initial		50.700	ANL-CUP-AR.pdf

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

ANL-AVI-AR	Application/ Enrollment Form	Aviation Questionnaire	Initial	57.800	ANL-AVI-AR.pdf
ANL-MOT-AR	Application/ Enrollment Form	Motor Sports Questionnaire	Initial	66.500	ANL-MOT-AR.pdf
ANL-RAC-AR	Application/ Enrollment Form	Racing Questionnaire	Initial	62.100	ANL-RAC-AR.pdf
ANL-CPA-AR	Application/ Enrollment Form	Chest Pain Questionnaire	Initial	77.800	ANL-CPA-AR.pdf
ANL-SPO-AR	Application/ Enrollment Form	Sports Amusement and Aviation Questionnaire	Initial	50.700	ANL-SPO-AR.pdf
ANL-DIS-AR	Application/ Enrollment Form	Disabled Applicant Questionnaire	Initial	50.700	ANL-DIS-AR.pdf
ANL-ABP	Application/ Enrollment Form	Additional Beneficiary Page	Initial	73.400	ANL-ABP.pdf

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Military Status Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* M L Q *

Name _____ File # _____

1) Of what branch of service are you a member? _____

2) Present duty status? ❑ Active ❑ Active Reserve ❑ Inactive Reserve ❑ National Guard ❑ ROTC

3) Present rank: _____

4) Present unit: _____

5) Military occupational specialty: _____

6) Address of present unit: _____

7) Present assignment: _____

8) To your knowledge, have you been told or are you aware that:

a) You will be transferred overseas? ❑ Yes ❑ No

If Yes, where? _____

b) You or your unit will be alerted for duty (if presently in the Reserve or National Guard)? ❑ Yes ❑ No

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this military history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Foreign Travel Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: [PO Box 696700 San Antonio, TX 78269-6700] Business: [(800) 899-6806] Fax: [(888) 237-1012]

Name _____ File # _____

Please provide details of foreign travel including holidays and short business trips within the last two (2) years.

1. Within the last two (2) years:

Date(s) of Visit(s)	Countries	Regions	Reason for Visit(s)	Duration of Visit(s)

2. Future Intentions: (limited to two (2) years)

Date(s) of Visit(s)	Countries	Regions	Reason for Visit(s)	Duration of Visit(s)

3. Please give a brief description of your duties while traveling or residing abroad. _____

4. Do you expect to visit non-urban areas? ❑ Yes ❑ No
   If Yes, please give details of:
   a) Your probable accommodations: _____
   b) The availability of medical facilities: _____
   c) Your travel arrangements (example: Light Aircraft, Boat): _____
5. Are you a U.S. Citizen: ❑ Yes ❑ No
   If No, of what country are you now a citizen? _____
   What visa do you hold? ❑ Permanent ❑ Temporary Expiration date: _____
6. Do you maintain a foreign residence? ❑ Yes ❑ No
   If Yes, please provide address: _____
   How often do you visit this residence? _____
   What is the duration of typical stay or visit? _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____
Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this foreign travel history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Diabetic Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806 Fax (888) 237-1012]

* D B Q *

Name _____ Birthdate _____ File # _____

1. Date diabetes diagnosed by a member of the medical profession? _____
2. Type of treatment? ❑ Insulin ❑ Oral Medication ❑ Diet only

   Type of insulin and/or oral medication: _____

   Dosage and frequency: _____
3. Do you follow a diabetic diet? ❑ Yes ❑ No
4. Have you had any fasting blood sugars performed in the past six (6) months? ❑ Yes ❑ No If Yes, results: _____
5. Results and date of your most recent Hgh A1c (glycosylated hemoglobin), if known: _____
6. How often do you test your blood for glucose? _____
7. Since your treatment began, have you ever had a diabetic coma or insulin shock? ❑ Yes ❑ No

   If Yes, when? _____
8. Within the last twelve (12) months have you been diagnosed by a member of the medical profession as having skin infections, skin ulcers, or ever had any amputations? ❑ Yes ❑ No

   If Yes, explain: _____
9. Have you been diagnosed by a member of the medical profession as having any visual problems (other than corrective lenses), heart or circulatory problems, albumin or protein in your urine, loss of consciousness, or numbness or tingling in your feet or legs? ❑ Yes ❑ No

   If Yes, explain: _____
10. How many days have you lost from work due to diabetes in the last two (2) years? _____

    If any time off from work was due to diabetes in the past two (2) years, provide details including dates and duration of time off from work: _____
11. Name, address, and phone number of the doctor or clinic supervising your treatment:

    Date of last consultation? _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this diabetic history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Epilepsy/Seizure Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* E S Q *

Name _____ Birthdate _____ File # _____

1. Date diagnosed by a member of the medical profession: _____
2. Type of seizure disorder (if known): ❑ absence/petite mal ❑ tonic clonic/grand mal ❑ other: _____
3. Has a cause been determined by a member of the medical profession? _____
4. Have you had any CT-scans or MRI's of the brain in the past year? ❑ Yes ❑ No

   If Yes, what were the results? _____

   Name, address and phone number of the hospital/clinic/physician that would have a copy of this test:

   _____

   _____

   _____
5. Number of seizures or convulsions per year: _____
6. Date of the last seizure or convulsion: _____
7. Please list medications currently used for seizures including dosage, and how often taken: _____

   _____
8. If no longer on medication, when did you discontinue treatment and was the medication discontinued at the advice of a medical professional? _____

   _____

   _____
9. Name, address, and phone number of the doctor who would have the most current and complete information about your condition:

   _____

   _____

   _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this epilepsy/seizure history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Scuba Diving Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address:[PO Box 696700 San Antonio, TX 78269-6700]Business[(800) 899-6806]Fax[(888) 237-1012]

Name _____ File # _____

1. Level of certification? ❑ basic ❑ open water ❑ advance open water ❑ master diver ❑ dive master ❑ instructor
   ❑ other: _____
2. a) What are the locations of your diving activities? (example: cave, under ice, inland waters, ocean, ship wrecks) _____
   b) If you are a cave diver, are you certified by NACD (National Association for Cave Diving or NASDS (National Association of Scuba Diving Schools)? ❑ Yes ❑ No
   c) Do you ever participate in any night diving? ❑ Yes ❑ No
3. Are you currently certified by one of the national training and certification organizations? ❑ Yes ❑ No
   Name of the organization(s)? _____
4. Are you a member of an organized club? ❑ Yes ❑ No
5. Do you ever dive alone? ❑ Yes ❑ No
6. Do you dive or do you contemplate diving for compensation within the next two (2) years? ❑ Yes ❑ No
7. Do you ever dive for depth records? ❑ Yes ❑ No
8. Do you ever dive using experimental equipment? ❑ Yes ❑ No

IF "YES" FOR ANY OF THE ABOVE, PLEASE GIVE DETAILS BELOW UNDER "REMARKS".

9. Particulars of diving:

Depth of Dive	Past 12 Months No. of Dives	Avg. Time Under Water per Dive	Expected Next 12 Months No. of Dives
To 50 ft. or less			
To 75 ft.			
To 100 ft.			
To 150 ft.			
To 200 ft.			
Over 200 ft.			

Date of last dive: _____

10. REMARKS: _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this scuba diving history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Respiratory Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: [PO Box 696700, San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* R S Q *

Name _____ Birthdate _____ File # _____

1. a) Have you been diagnosed by a member of the medical profession as having: ❑ bronchitis ❑ asthma ❑ emphysema ❑ chronic cough ❑ wheezing ❑ chronic obstructive pulmonary disease ❑ pneumonia ❑ shortness of breath ❑ other (explain): _____

   b) Has the cause been determined by a member of the medical profession? _____
2. How often does the condition indicated above occur? _____
3. Date of last occurrence as documented by a member of the medical profession: _____
4. Are the occurrences considered ❑ Mild ❑ Moderate ❑ Severe as documented by a member of the medical profession?
5. As diagnosed by a member of the medical profession, indicate the pattern of your attacks in the past five (5) years:

   ❑ no change in symptoms ❑ improvement in symptoms ❑ increasing symptoms or more severe attacks
6. Have you lost time from work? ❑ Yes ❑ No If Yes, when, how long, and why? _____
7. In the past five (5) years, have you been hospitalized for a respiratory disorder diagnosed by a member of the medical profession? ❑ Yes ❑ No If Yes,

Hospital	City, State & ZIP	Approximate date(s)

8. Provide the name(s) of the medications or types of treatments as prescribed or performed by a member of the medical profession for the respiratory conditions(s) indicated: _____

   Name, address, and phone number of primary physician for respiratory condition: _____
9. Has a member of the medical profession performed any pulmonary function studies or tests? ❑ Yes ❑ No

   If Yes, date and results: _____
10. Do you use tobacco in any form? ❑ Yes ❑ No If Yes, type and amount per day: _____

    If used in the past and quit, number of years, quantity and date of last use. _____
11. Have you been prescribed or provided medical advice by a member of the medical profession to use supplemental oxygen? ❑ Yes ❑ No

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this respiratory history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Blood Pressure Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

Name: _____ Birthdate: _____ File #: _____

1. What was your highest blood pressure reading? _____ Please provide the date of this reading: _____
2. What was your lowest blood pressure reading? _____ Please provide the date of this reading: _____
3. Have you received treatment from a member of the medical profession for blood pressure? _____ If "yes:"
   A. Name, address and phone number of doctor(s): _____
   _____
   B. When did treatment begin? _____
   C. Last blood pressure reading and date of visit: _____
   D. Medication(s) prescribed and dosage: _____
4. Have you been diagnosed or treated by a member of the medical profession for any of the following?

   ❑ Stroke ❑ Severe headaches ❑ High cholesterol ❑ Heart Disease ❑ Diabetes ❑ Chest pains
   ❑ Circulation problems ❑ Other

   Please provide details. _____
   _____
   _____
5. Have you had any special studies performed by a member of the medical profession: (X-Rays, EKG, Lab Tests, etc.)? If yes, please provide the results: _____
   _____
   _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____
Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this blood pressure history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Drug Use Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* D G Q *

Name _____ Birthdate _____ File # _____

1. Do you use or have you used:		Yes	No
a)	Narcotics (example: codeine, heroin, morphine, opium, methadone, demerol, percodan, dilaudid)?	❑	❑
b)	Hallucinogens (example: lysergic acid diethylamide (LSD), mescaline, phencyclidine (PCP), peyote)?	❑	❑
c)	Cannabis (example: marijuana, hashish, tetrahydrocannabinol (THC))?	❑	❑
d)	Stimulants (example: cocaine, crack, benzedrine, methamphetamine, amyl nitrite)?	❑	❑
e)	Sedatives (example: tuinal, seconal, nembutal)?	❑	❑
f)	Tranquilizers (example: librium, valium, diazepam, halcion, quaalude)?	❑	❑
g)	I.V. (intravenous - injected by needle into blood vien) Drug use.	❑	❑
h)	Any other substance abuse?	❑	❑

2. If Yes for any of the above, please give details below:

Drug Used	Frequency (No. of times per week)	Dates Used From (mo/yr) To(mo/yr)	Name and Address of Prescribing Physician (if applicable)

3. Have you ever been suspended or terminated from employment due to drug related causes? ❑ Yes ❑ No
If Yes, give details: _____

4. a) Have you ever sought, received, or been advised to receive treatment because of your drug use? ❑ Yes ❑ No
If Yes, indicate number of times treated _____, date(s) of treatment _____, name, address, and phone number of any doctor, hospital, or treatment center involved. _____

b) Have you ever been diagnosed or treated by a member of the medical profession for any medical complications as a result of drug use? ❑ Yes ❑ No If Yes, explain: _____

5. Have you ever plead guilty to or been charged with any offense involving drugs, including driving under the influence of drugs or alcohol? ❑ Yes ❑ No If Yes, give details and driver's license number: _____

6. Do you or have you attended Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or any 12-step program or support group for alcohol or drugs? ❑ Yes ❑ No If Yes, date first attended: _____ Date last attended: _____

7. Please add any additional information which you feel is important concerning your use of drugs: _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this drug use history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Alcohol Use Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

ALQ

Name _____ Driver's License # _____ State Issued _____

File # _____

1. Do you presently use or have you in the past used alcoholic beverages? ❑ Yes ❑ No

	PRESENT USE OF ALCOHOL				PAST USE OF ALCOHOL			
	Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From:	To:	Quantity Used	Frequency (Daily, Weekly, Monthly)	Dates Used From:	To:
Beer								
Wine								
Other Alcohol								

2. Have you changed your drinking habits? ❑ Yes ❑ No If Yes, why? _____

3. Have you ever consulted or been advised to consult, a hospital, physician or practitioner, or received treatment for your alcohol use? ❑ Yes ❑ No If Yes, date: _____
   Treatment Center/Doctor's Name: _____
   Address: _____ City and state: _____ ZIP: _____ Phone #: _____
4. Are you presently being treated by a member of the medical profession for alcohol use? ❑ Yes ❑ No
5. Are you attending or have you ever attended any alcohol related, self-help organizations (example: Alcoholic Anonymous)?
   ❑ Yes ❑ No If Yes, last date attended: _____
   Name of organization: _____ How often do you attend? _____
   Date of first attendance: _____ Do you still attend meetings? ❑ Yes ❑ No
6. Have you ever been convicted for driving while under the influence of alcohol? ❑ Yes ❑ No
   If Yes, number of times: _____ Date(s): _____
7. Have you ever been suspended or terminated from employment due to alcohol related causes? ❑ Yes ❑ No
   If Yes, furnish details: _____
8. Have you ever been diagnosed by a member of the medical profession with or treated for any medical complications as a result of alcohol use? ❑ Yes ❑ No If Yes, conditions such as: ❑ Pancreatitis ❑ Gastritis ❑ Liver problems ❑ Other: _____
9. In the past five (5) years, have you used any drug or narcotic (except prescribed by a physician) or received treatment or counseling from a member of the medical profession for drug use? (Drugs include, but are not limited to: barbiturates, heroin, cocaine, opiates, amphetamines, marijuana and hallucinogens.) ❑ Yes ❑ No If Yes, please explain: _____
   Furnish dates, name, address, and phone number of doctor(s) or medical facilities: _____
10. Please include any additional information which you feel is important.

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this alcohol use history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Check-up Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

Name _____ File # _____

1. What was the purpose of the check-up? (Example: Employment, School, License Requirement, Health Related)

   _____

2. Diagnosis by member of medical profession:

   Date of diagnosis by member of medical profession: _____

   Treatment/medications prescribed by member of medical profession: _____

   _____

   Name, address and phone number of attending physician: _____

   _____

3. Is any future testing, surgery, or treatment required or recommended by a member of the medical profession? ❑ Yes ❑ No

   If Yes, provide details: _____

   _____

4. If referred to another physician or medical facility, provide name, address, and date of attendance: _____

   _____

5. Please include any additional information which you feel is important: _____

   _____

   _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this check-up history.

AMERICAN NATIONAL

American National Life Insurance Company of Texas

Aviation Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* A Q U *

Name _____ Birthdate _____ File # _____

1. a) Type of certificate or license now held? ❑ Student — If student, when did the proposed insured first obtain a student pilot's certificate? _____
   ❑ Private ❑ Commercial ❑ ATR (Airline Transport Rating) Other (specify): _____
   b) Does the proposed insured have an instrument flight rating? ❑ Yes ❑ No
   c) Total number of hours flown as a pilot? _____
   d) What percentage of the proposed insured's flying time is
      i) with a qualified co-pilot? _____
      ii) in a single engine plane? _____
      iii) in a multi-engine plane? _____
2. If not a pilot, specify the capacity in which the proposed insured flies. (example: flight surgeon, photographer, crew member): _____
3. a) When did the proposed insured last fly as a pilot or crew member? _____
   b) Type of aircraft? (specify alphabetic and numeric code, propeller or jet, and give brief description.)
4. Has the proposed insured flown, or does the Proposed Insured intend to fly outside the United States within the next two (2) years? ❑ Yes ❑ No
   If Yes, explain: _____
5. Has the proposed insured ever had an aircraft accident or been grounded, fined, or reprimanded for violation of air regulations? ❑ Yes ❑ No
   If Yes, give details: _____

Complete the following chart as it may apply

Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago	Type of Flying	Hours Contemplated Next 12 Months	Hours Past 12 Months	Hours One to Two Years Ago
Commercial (Flying for pay) Scheduled Passenger Airline				Non-Commercial (Not Flying For pay) Pleasure			
Employer owned aircraft for employee transportation				Personal Business Transportation			
Other Freight Carrying or Passenger Service				Instruction As Student			
Student Instructor				Other (Ultralight,Glider, Etc)			
Crop Dusting/ Aerial Spraying							
Military							

If we find your flying activities involve an extra hazard that requires an exclusion or an extra premium charge, please indicate your choice.

❑ Policy to include aviation coverage at appropriate extra premium. Despite payment of an additional premium for aviation coverage on the base policy, the aviation exclusion included in any accidental death benefit rider which may be issued with or become part of, the policy will still be in effect.

❑ Policy to incorporate aviation exclusion rider.

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this aviation history.

AMERICAN NATIONAL

American National Life Insurance Company of Texas

Motor Sports Questionnaire

Issued by American National Life Insurance Company of Texas

[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address:[PO Box 696700 San Antonio, TX 78269-6700]Business[(800) 899-6806]Fax[(888) 237-1012]

* M S Q *

Name _____ Driver's License # _____ State Issued _____

File # _____

1. ☐ Amateur ☐ Professional
2. Do you engage in exhibitions or organized competitive motor sports? ☐ Yes ☐ No
3. Check below each type(s) of event(s) you pursue. Please give details in remarks section below:

☐ All terrain (ATV)
☐ Auto - crash
☐ Auto - ice
☐ Championship cars
☐ Demolition or destruction derby
☐ Drag racing
☐ Dune/sand buggy or cycle
☐ Economy runs
☐ Figure 8 demolition derby
☐ Football/auto football demolition derby or soccer
☐ Formula racing
☐ Gyro - stabilized land or water vehicles
☐ Hill climb
☐ Hovercraft and hydrofoils; amphibians
☐ Jet car exhibitions
☐ Kart racers
☐ Midget cars
☐ Mini cars
☐ Motorcycles
☐ Off road, desert, trail competition
☐ Rally
☐ Scooters
☐ Snowmobiles
☐ Sports cars
☐ Sprint cars
☐ Stock cars
☐ Time speed trials
☐ Wheelie competitions
☐ Others (explain in remarks below)

Types Of Races*	Maximum Speed	Last 12 Months		1-2 Years Ago		Prior to 2 Years Ago		Contemplated Next 12 Months	
		Races	Miles	Races	Miles	Races	Miles	Races	Miles

(*Midget, Sport Car, Stock-Car, Championship, Drag, Motorcycle)

4. What specific type of event do you compete in with the above vehicle(s)? (example: road race, endurance, sprint, motorcross) _____
5. Please furnish the following information:
   a) What type of vehicle do you operate? _____ b) What make & model? _____
   c) Is it modified? _____ d) What is the HP (horsepower)? _____ e) Engine size? _____
   f) Engine displacement? _____ g) Class? _____ h) Type of fuel? (example:gas, nitro) _____
6. Under what sanctioning body do you normally compete? (Example: AMA (American Motorcyclist Association), NHRA (National Hot Rod Association), SCCA (Sports Car Club of America), USAC (United States Auto Club)) _____
7. Do you anticipate any changes in your participation in the coming twelve (12) months? If Yes, give details.
   (example: Different events, new class) _____
8. Have you had any moving traffic violations in the past three (3) years? ☐ Yes ☐ No If Yes, please furnish details: _____
9. Remarks: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this motor sports history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Racing Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

RQU

Name _____ Birthdate _____ File # _____

1. Have you engaged in during the last 12 months, or do you contemplate engaging in the next 12 months, in any of the following form(s) of racing?

Automobile	❑ Yes	❑ No
Motorcycle	❑ Yes	❑ No
Motorboat	❑ Yes	❑ No
Hydroplane	❑ Yes	❑ No
Other(s)	❑ Yes	❑ No If Yes, specify: _____

If Yes, give details below:

Types of Racing*	1-2 Years Ago		Last 12 Months		Average Speed of Fastest Race	Fastest Speed Attained	Contemplated Next 12 Month	
	Number of Races	Total Miles Raced	Number of Races	Total Miles Raced			Number of Races	Total Miles

*Examples
Automobile — midget, sports car, stock car, championship, drag, kart
Motorcycle — hill climbing, cross country, circular track
Motorboat — unmodified, modified, experimental
Unlimited hydroplane — jet, other

2. Do you own a competitive vehicle(s)? _____ If Yes, give type(s): _____
3. Over what period of the year do you race? (example: month, six months, entire year) _____
4. How far do you travel to race? _____
5. Have you ever competed or do you contemplate competing outside the United States in the next 12 months? _____
   If Yes, give details: _____
6. Over what type of track do you race? (example: oval, simulated road) _____
7. Do you race professionally or for cash prizes? _____
8. Additional remarks clarifying answers to above questions: _____

Fraud Warning

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I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

Proposed Insured's Signature _____ Date _____

Please use the back of this sheet, if necessary, to report details which will clarify this racing history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Chest Pain Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

Name _____ Birthdate _____ File # _____

	YES	NO
1. Have you ever been diagnosed with or been treated by a member of the medical profession for:		
a) Chest pain?	☐	☐
b) Palpitation? Skipping of heart?	☐	☐
c) Shortness of breath?	☐	☐
d) High blood pressure?	☐	☐
2. If pain was experienced in chest did it involve:		
a) Middle of chest?	☐	☐
b) Left side of chest?	☐	☐
c) Left shoulder, arm or hand?	☐	☐
d) Both shoulders or arms?	☐	☐
e) Sense of pressure or constriction?	☐	☐
f) Sweating	☐	☐
g) Was it associated with:		
Exertion? Exercise?	☐	☐
Excitement? Strain?	☐	☐
h) Emergency medical care?	☐	☐

Please give details of all Yes answers - dates, durations, results, doctors' names and addresses.

3. If Yes answers, please report:
   a) Approximate date of first attack? _____
   b) Date of last attack? _____
   c) How frequent: per day, week or month? _____
   d) Duration of average attack? _____
   e) Were you hospitalized? How long? _____
   f) Were you confined at home? How long? _____
   g) How long convalescent? _____
   h) Date of return to work? Restrictions? _____
   i) How many hours do you work daily? _____
   j) What medicine are you now taking? _____

4. Please give names and addresses of all your attending doctors. _____

5. What diagnosis was made, by a member of the medical profession, concerning your chest pain or heart condition? _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this medical history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Sports, Amusement, or Avocation Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

* S A Q *

Name _____ Birthdate _____ File # _____

(Do not use for aviation, motor sports, racing, or scuba)

Instructions:

1. Answer each question with as much detail as possible. Additional information may be put on back.
2. If more than one sport or avocation is participated in, use separate questionnaire.
3. For Aviation use Aviation Questioinnaire; for Scuba use Scuba Diving Questionnaire; for Motor Sports use Motor Sports Questionnaire; for Racing use Racing Questionnaire

Examples when form is required:

- Ballooning
- Bungee Jumping
- Hang Gliding
- Horse Racing
- Mountaineering
- Parachuting
- Powerboat Racing
- Rock Climbing
- Snowmobiling
- Spelunking

1. What is the activity in which you participate? _____
2. What national clubs or associations are you affiliated with in connection with this activity? _____
3. List any special licenses, professional or amateur titles you hold in connection with this activity: _____
4. Do you participate for monetary gain or profit? ❑ Yes ❑ No If Yes, give details: _____

   Earnings: This year _____ Last year _____ 2 years ago _____ 3 years ago _____
5. In what geographical locations do you normally participate in this sport or avocation? (example: specific track or body of water, composition and shape of track, state or foreign country) _____
6. Do you or have you ever participated in any experimental forms of this sport or avocation? ❑ Yes ❑ No

   If Yes, give full details: _____
7. How long have you been participating in this sport or avocation? _____
8. How many times did you participate in the past twelve (12) months? _____
9. How frequently do you expect to participate in the next twelve (12) months? _____
10. What is the greatest height/depth/speed you have obtained? _____
11. How many times have you attained this height/depth/speed? _____
12. What is the average height/depth/speed? _____
13. What is the average length of time you spend in each instance of participation in this activity? _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this sports, amusement, or avocation history.

AMERICAN NATIONAL
American National Life Insurance Company of Texas

Disabled Applicant Questionnaire

Issued by American National Life Insurance Company of Texas
[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address [PO Box 696700 San Antonio, TX 78269-6700] Business [(800) 899-6806] Fax [(888) 237-1012]

Name _____ File # _____

1. What disability have you been diagnosed, treated, tested positive for, or been provided medical advice for by a member of the medical profession? _____

2. As diagnosed by a member of the medical profession, when was the onset of the disability? _____
3. Was there a cause for the above diagnosed disability? _____
4. Does the above diagnosed disability affect your ability to work or carry out normal daily activities including bathing, dressing, grooming and homemaking? ❑ Yes ❑ No

   If yes, give details _____

5. What was your job prior to your disability? _____
6. When do you expect to return to work? _____
7. Are you currently receiving Worker's Compensation, Unemployment or Disability payments? ❑ Yes ❑ No
8.

Name, Address, Phone No. Physician & Hospitals	Conditions and Details	Date	How Often Seen

9. Additional Remarks: _____

Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

_____ _____

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this disabled history.

AMERICAN NATIONAL

American National Life Insurance Company of Texas

Application - Additional Beneficiary Page for Life Insurance

Issued by American National Life Insurance Company of Texas

[One Moody Plaza, Galveston, TX 77550-7947]

Mailing Address: PO Box 696700, San Antonio, TX 78269-6700

Business [(800) 899-6806] Fax [(888) 237-1012]

* B E N E A P P *

Provide corresponding application / policy number: _____ / Select the appropriate box for which this page applies.

❑ **Primary Proposed Insured** ❑ **Additional Proposed Insured**

1. PRIMARY PROPOSED INSURED

a. Last name | First name | M.I. | Social Security/Tax ID number

b. Date of birth: Month/Day/Year | c. Residence address: Number/Street | d. City | e. State | f. ZIP

2. OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

a. Last name | First name | M.I. | Social Security/Tax ID number

b. Date of birth: Month/Day/Year | c. Residence address: Number/Street | d. City | e. State | f. ZIP

3. ADDITIONAL BENEFICIARY INFORMATION *(Unless specified, all beneficiaries in the same class share equally.)*

Primary: Last name	First name	M.I.	Relationship to Proposed Insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

Contingent: Last name	First name	M.I.	Relationship to Proposed Insured	Date of Birth: Mo./Day/Yr.	Gender	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

4. USE FOR ADDITIONAL BENEFICIARY DESIGNATIONS OR FOR SPECIAL BENEFICIARY SETTLEMENT OPTIONS:

Date: Month/Day/Year

Signature of Primary Proposed Insured (Or guardian, if Proposed Insured is under age 16)

X _____

Witnessed by: Signature of licensed agent

X _____

Signature of additional person(s) proposed for insurance

X _____

Print agent's name

Signature of additional person(s) proposed for insurance

X _____

Agent's state license number / company personal code

Signature of owner if other than Proposed Insured

X _____

SERFF Tracking Number:	*AMNA-127137079*	*State:*	*Arkansas*
Filing Company:	*American National Life Insurance Company of Texas*	*State Tracking Number:*	*48729*
Company Tracking Number:	*QUESTIONNAIRES*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Questionnaires*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR ANTEX Questionnaires - Certification of Compliance.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
ANL-3409AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR Cover Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Variability
Comments:
Attachments:
MVM-ANL-ABP.pdf
MVM-AR Questionnaires.pdf

American National Insurance Company of Texas

CERTIFICATION OF COMPLIANCE

The Company has reviewed the captioned form(s) below, and certifies that to the best of its knowledge and belief, the form(s) submitted is (are) in compliance with the following:

Rule & Regulation 19
Rule & Regulation 49
ACA 23-79-138 and Bulletin 15-2009
ACA 23-80-206 (Flesch Certification, minimum of 40)

Form	Form Name	Scoring(s)
ANL-MIL-AR	Military Status Questionnaire	66.5
ANL-FOR-AR	Foreign Travel Questionnaire	57.9
ANL-DIA-AR	Diabetic Questionnaire	61.2
ANL-EPI-AR	Epilepsy/Seizure Questionnaire	61.5
ANL-SCU-AR	Scuba Diving Questionnaire	57.9
ANL-RES-AR	Respiratory Questionnaire	62.1
ANL-BLO-AR	Blood Pressure Questionnaire	60.3
ANL-DRU-AR	Drug Use Questionnaire	55.9
ANL-ALC-AR	Alcohol Use Questionnaire	52.1
ANL-CUP-AR	Check-up Questionnaire	50.7
ANL-AVI-AR	Aviation Questionnaire	57.8
ANL-MOT-AR	Motor Sports Questionnaire	66.5
ANL-RAC-AR	Racing Questionnaire	62.1

Tyra.Reed@anico.com
Phone: (409) 763-4661 x5222 Fax: (409) 766-6933

ANL-CPA-AR	Chest Pain Questionnaire	77.8
ANL-SPO-AR	Sports Amusement or Aviation	50.7
ANL-DIS-AR	Disabled Applicant Questionnaire	50.9
ANL-ABP	Additional Beneficiary Page	73.4

Rex D. Hemme
Senior Vice President & Actuary
American National Insurance Company

Tyra.Reed@anico.com
Phone: (409) 763-4661 x5222 Fax: (409) 766-6933

AMERICAN NATIONAL

American National Life Insurance Company of Texas

Application for Individual Life Insurance Policy

Issued by American National Life Insurance Company of Texas

[One Moody Plaza, Galveston, TX 77550-7947] Phone Number [877-862-0759]

* A P P *

Mailing Address: [PO Box 696700 San Antonio, TX 78269-6700]

Any telephone conversation will be recorded and the information you provide is your application for life insurance.

1. Proposed Insured _____ Social Security Number _____
   First Name Middle Initial Last Name
   Birthdate (Mo-Day-Yr) _____ Age _____ Sex _____ Birthstate/Birthplace _____
   Height _____ Weight _____ Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced
   Occupation _____ Has the Proposed Insured used tobacco or nicotine in the past 12 months? ☐ Yes ☐ No
   Residence Address: _____
   Number and Street
   City, State and Zip _____ Home Phone _____
2. Owner _____ Social Security Number _____ Date of Birth _____
   Address _____ Relationship _____

Unless specified, all Beneficiaries in the same class share equally.

3.

Primary: Last name	First name	M.I.	Relationship to Proposed Insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

Contingent: Last name	First name	M.I.	Relationship to Proposed Insured	Date of Birth: Mo./Day/Yr.	Gender: M/F	Soc. Sec./Tax ID#	Date of trust: Mo./Day/Yr.	% payable

If more space is needed, complete the state appropriate form for additional beneficiary designations.

4. a. Do you have any existing life insurance or annuity coverage? ☐ Yes ☐ No If yes, provide details below.
   b. Will the life insurance applied for replace or use cash values of any existing life insurance or annuity policy issued by any company? ☐ Yes ☐ No
   If Yes, Indicate which ones _____
5. Has the Proposed Insured, in the past 5 years, made - or is any Proposed Insured contemplating making - flights as a pilot, student pilot, crew member, or observer? (If "Yes," complete and submit the appropriate questionnaire.) ☐ Yes ☐ No

PART 1 (Proposed Insured is not eligible for life insurance if any question in PART 1 is answered "Yes." If all questions are answered "No," proceed to PART 2.)

6. Is the Proposed Insured currently hospitalized, in a nursing home, under hospice care, or confined to a wheelchair due to disease or illness, or in need of personal or mechanical assistance in bathing and/or dressing? ☐ Yes ☐ No
7. In the past 2 years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a heart attack, stroke, emphysema, cirrhosis of the liver or cancer (other than non-melanoma skin cancer)? ☐ Yes ☐ No
8. Has the Proposed Insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for human immunodeficiency virus (AIDS virus), Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)? ☐ Yes ☐ No
9. Has the Proposed Insured ever received an organ transplant or been on a waiting list for an organ transplant? ☐ Yes ☐ No
10. Has the Proposed Insured ever received kidney dialysis, heart valve replacement, or an implanted defibrillator? ☐ Yes ☐ No
11. Has the Proposed Insured ever been diagnosed by a member of the medical profession with any of the following conditions: congestive heart failure, cardiomyopathy, Alzheimers, dementia, aneurysm, chronic hepatitis B or C, or renal failure? ☐ Yes ☐ No
12. Has the Proposed Insured ever been diagnosed by a member of the medical profession with chronic obstructive pulmonary disease (COPD)? ☐ Yes ☐ No
13. In the past 10 years, has the Proposed Insured been diagnosed by a member of the medical profession with or received treatment for leukemia or lymphoma (Hodgkins or non-Hodgkins)? ☐ Yes ☐ No
14. In the past 5 years, has the Proposed Insured received treatment for alcohol or drug use, been diagnosed by or treated by a member of the medical profession for internal cancer, malignant melanoma, stroke, cerebral vascular accident (CVA), transient ischemic attack (TIA) or pancreatitis? ☐ Yes ☐ No
15. In the past 2 years, has the Proposed Insured been diagnosed by a member of the medical profession for coronary artery disease, or atrial fibrillation, or had coronary bypass surgery, coronary angioplasty, coronary stenting or pacemaker implantation? ☐ Yes ☐ No

AMERICAN NATIONAL

American National Life Insurance Company of Texas

PART 2 (Proposed Insured may require graded death benefit if any of the following is answered "Yes." If all questions are answered "No," Proposed Insured may qualify for level death benefit).

16. Has the Proposed Insured ever been diagnosed by a member of the medical profession with major depression, bipolar disorder, diabetes (requiring insulin), rheumatoid arthritis, multiple sclerosis, or Parkinson's disease? ☐ Yes ☐ No
17. Has the Proposed Insured ever been diagnosed or treated by a member of the medical profession for a heart attack, coronary artery disease, atrial fibrillation or had coronary bypass surgery, coronary angioplasty or coronary stenting? ☐ Yes ☐ No
18. In the past 5 years, has the Proposed Insured been diagnosed by a member of the medical profession with or received treatment for Crohn's disease or ulcerative colitis? ☐ Yes ☐ No
19. Has the Proposed Insured ever been diagnosed by a member of the medical profession with one of the following conditions: internal cancer or malignant melanoma? ☐ Yes ☐ No
20. Has the Proposed Insured been diagnosed by a member of the medical profession as having a stroke, cerebral vascular accident (CVA) or transient ischemic attack (TIA) more than 5 years ago? ☐ Yes ☐ No
21. Plan Type: ☐ Level Death Benefit ☐ Graded Death Benefit
    Initial Premium Payment _____ Face Amount _____ Payment Method _____ Payment Mode _____

FRAUD WARNING — Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

APPLICATION DECLARATIONS AND AGREEMENTS — Each of the undersigned declare for themselves and all other interested parties, that all of the answers in all pages of this application and any supplements to it are complete and true to the best of their knowledge and belief. They also agree that:

1. these answers as written: a) were given to induce American National Life Insurance Company of Texas to issue a Policy; and b) shall form the basis for and become part of any Policy issued on the application;
2. except as otherwise provided in the conditional receipt no Policy will be effective until, during the lifetime of the Proposed Insured, it is: a) issued; b) delivered to the Applicant; c) the full first premium paid; and d) the Proposed Insured is in the same health as stated in the application;
3. American National Life Insurance Company of Texas may issue a Policy different from that specified in this application by listing the difference(s) on the Policy Data page, and acceptance of such different Policy will be an acceptance of the changes except that no changes in: a) specified amount; and/or b) classification or c) plan of insurance will be effective unless agreed to by the Owner in writing;
4. American National Life Insurance Company of Texas is not bound by any statements made by anyone or any other facts known to anyone concerning the Proposed Insured if not in writing in this application or any supplement to it; and
5. only the President, a Vice President, or the Secretary of American National Life Insurance Company of Texas has the authority to waive any of American National Life Insurance Company of Texas' rights or requirements or to waive or alter any of the provisions of this application or the Policy issued on this application.

I have received the notification regarding the Federal Fair Credit Report Act and the Medical Information Bureau. If this life insurance application is being completed over the telephone, this notice has been read to me and a copy of the notice will be provided with the policy.

If this life insurance application is being completed over the telephone, your verbal consent by voice recording is required and will constitute an electronic signature under the law. If you agree to the statements just read to you and you consent to the use of this voice recording as an electronic signature for this life insurance application, please state your name, date of birth, and "I agree."

_____	_____	_____
Dated at City, State	Date	Print Agent's Name
_____	_____	_____
Proposed Insured's Signature	Witnessed by: Agent's Signature	Agent's company personal code
_____		_____
Owner's Signature		License Identification Number

American National Life Insurance Company of Texas

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to American National Life Insurance Company of Texas, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on American National Life Insurance Company of Texas or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that American National Life Insurance Company of Texas underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it in accordance with other federal and state laws, resulting in a loss of protection by federal regulations.

I understand that:

1. such information will be used by American National Life Insurance Company of Texas for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. I or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, at any time, except to the extent that action has been taken in reliance on this authorization by sending written notice to the Life New Business Department of American National Life Insurance Company of Texas,[One Moody Plaza, Galveston, Texas 77550-7947] I may inspect or copy any information used or disclosed under this authorization, if signed.

If this life insurance application is being completed over the telephone, your verbal consent by voice recording is required and will constitute an electronic signature under the law. If you agree to the authorization just read to you and you consent to the use of this voice recording as an electronic signature, please state your name, date of birth, and "I agree."

_____
Date

_____
Signature of Owner

_____
Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other.

SIGNATURE REQUIRED IF INITIAL PREMIUM WAS MADE

I hereby certify that I have read and received the conditional receipt, and agree to its terms. I understand that American National Life Insurance Company of Texas will not permit acceptance of my payment unless this statement is true.

_____
Signature of Proposed Insured

_____
Signature of Premium Payor

_____
Signature of Owner

American National Life Insurance Company of Texas

AUTHORIZATION TO MY BANK
PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

☐ **Checking** ☐ **Savings**

Bank Information

Name _____ City State Zip _____

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of American National Life Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

If you want this voice recording to constitute your electronic signature on this authorization to your bank, please state your name, birthdate and "I agree to this authorization."

Date Signed _____ Signature (as it appears on bank records) _____

Account Number _____ Routing Number _____

To be completed by Agent only

AGENT'S STATEMENT

If this application was taken on paper, I certify that I saw the Proposed Insured. I asked the Proposed Insured the questions in the application, and recorded the answers. The answers recorded did not conflict with my observations and knowledge of the Proposed Insured. I witnessed the required signatures.

If this life insurance application is being completed over the telephone, your verbal consent by voice recording is required and will constitute an electronic signature under the law. Please confirm that you have participated in the completion of the application over the telephone and consent to the use of this voice recording as an electronic signature by stating your name, date of birth, and "I agree."

Date _____ Agent's Signature _____

AGENT'S SUPPLEMENT

1. What is the purpose of this insurance? ☐ Personal ☐ Business
2. If beneficiary is not a relative, explain insurable interest: _____
3. How long have you personally known the Proposed Insured? _____
4. By whom will the premiums be paid? ☐ Owner ☐ Applicant ☐ Other
   If Other, explain: _____
5. As an agent, do you have knowledge or reason to believe that replacement of existing business may be involved? ☐ Yes ☐ No
6. Was the application voluntary or solicited? _____

AGENT'S REPORT (required only if this application was taken on paper)

During the interview, did you observe if the Proposed Insured had any physical or mental impairment with regard to walking, speaking, or clearly understanding the questions on the application? ☐ Yes ☐ No

The best time(s) to call for a telephone interview: _____

BE SURE TO INFORM YOUR CLIENT THAT A TELEPHONE INTERVIEW MAY BE CONDUCTED. If the Proposed Insured has a hearing problem, describe. _____

Additional Agent Instructions:

American National Life Insurance Company of Texas

* C R C T *

CONDITIONAL RECEIPT

THIS RECEIPT SHALL BE VOID IF ALTERED OR MODIFIED.

American National Life Insurance Company of Texas
[One Moody Plaza, Galveston TX 77550-7947]

PREMIUM CHECK(S) MUST BE MADE PAYABLE TO AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS. DO NOT MAKE CHECK(S) PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

For purposes of this receipt, "the Company" refers to American National Life Insurance Company of Texas.

I have received $ _____ in connection with an application for life insurance. If each of the following four conditions is satisfied fully, then, subject to the maximum amount limitation described below, insurance as provided by the terms and conditions of the policy applied for will become effective on the effective date, as defined below.

(1) The payment received with the application must equal the minimum initial premium required for the plan(s) and amount(s) of insurance applied for and the mode of premium payment selected;
(2) All initial application requirements must be completed;
(3) On the effective date, as defined below, all persons proposed for insurance must be in the same health as stated in the application and insurable at standard premium rates for the plan(s) and amount(s) of insurance requested in the application.
(4) There is no material misrepresentation in the application.

MAXIMUM AMOUNT LIMITATION: At no time and in no event shall the total liability of the Company under this receipt and all other receipts providing conditional insurance coverage with the Company on the lives of all the persons proposed for insurance exceed $50,000.

SPECIAL LIMITATIONS:

- If a proposed insured dies by suicide, the Company's liability under this Conditional Receipt is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.

EFFECTIVE DATE MEANS THE LATEST OF: (a) the date of completion of the application; (b) the date of completion of all medical exams and tests required by the Company; and (c) if the applicant requests a policy date which is later than the date of this receipt, the policy date requested by the applicant.

REFUND OF PAYMENT: If one or more of the above conditions 1, 2, 3, or 4 have not been satisfied fully, the Company's liability is limited to a refund of the amount paid. Only the president, a vice president or the secretary of the Company has the authority to waive any of the Company rights or requirements, or to waive or alter any of the provisions of this receipt or amend it in any way.

INITIAL APPLICATION REQUIREMENTS: Means (a) completion of all required parts of the application; (b) completion of the first medical examination, if required by the Company's underwriting rules; and (c) if more than one medical examination is initially required by the Company's underwriting rules due to the Proposed Insured's age or face amount applied for, completion of the subsequent medical examination.

Date: Month/Day/Year Signed at: City State Country

_____ | _____ | _____ | _____

Signature of licensed agent

X _____

I have read this Conditional Receipt. It has been explained to me by the agent.

Signature of Primary Proposed Insured

X _____

Signature of Owner

X _____

American National Life Insurance
Company of Texas

American National Life Insurance Company of Texas
[One Moody Plaza, Galveston TX 77550-7947]

In connection with your application, American National Life Insurance Company of Texas, or its reinsurers, may obtain medical and other information for evaluation purposes. American National Life Insurance Company of Texas may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. American National Life Insurance Company of Texas may also obtain an investigative consumer report on you.

[**MIB Pre-notification –** Information regarding your insurability will be treated as confidential. The American National Life Insurance Company of Texas or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree, Suite 400, Braintree, MA 02184-8734.

The American National Life Insurance Company of Texas or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

Tobie Brink, Life Policy Analyst III
Product Development – Actuarial
One Moody Plaza, 14th Floor
Galveston, Texas 77550

e-mail: tobie.brink@ANICO.com
Phone: (409) 763-4661 x 4265
Fax: (409) 766-6933

May 9, 2011

Arkansas Insurance Department
Compliance - Life and Health
1200 West Third Street
Little Rock AR 72201-1904

American National Life Insurance Company of Texas (NAIC: 71773 FEIN: 75-1016594) Filing of Supplemental Questionnaire forms:

ANL-MIL-AR	Military Status Questionnaire
ANL-FOR-AR	Foreign Travel Questionnaire
ANL-DIA-AR	Diabetic Questionnaire
ANL-EPI-AR	Epilepsy/Seizure Questionnaire
ANL-SCU-AR	Scuba Diving Questionnaire
ANL-RES-AR	Respiratory Questionnaire
ANL-BLO-AR	Blood Pressure Questionnaire
ANL-DRU-AR	Drug Use Questionnaire
ANL-ALC-AR	Alcohol Use Questionnaire
ANL-CUP-AR	Check-up Questionnaire
ANL-AVI-AR	Aviation Questionnaire
ANL-MOT-AR	Motor Sports Questionnaire
ANL-RAC-AR	Racing Questionnaire
ANL-CPA-AR	Chest Pain Questionnaire
ANL-SPO-AR	Sports Amusement or Aviation
ANL-DIS-AR	Disabled Applicant Questionnaire
ANL-ABP	Additional Beneficiary Page

SERFF Tracking Number AMNA- 127137079
Company Tracking Number: QUESTIONNAIRES

Dear Sir or Madam,

Please find the above referenced questionnaires attached for your department's review and approval. These are new forms and are not intended to replace any previously approved forms.

These forms will be used in conjunction with the application for life insurance ANL-3409AR approved under SERFF Tracking Number AMNA-127025091.

Within the application, there is medical history and other similar type questions used to assist us in determining the insurability and risk class of the applicant. For some of these questions, a 'yes' answer will prompt the use of a supplemental questionnaire in order to gather more information. In addition to a 'yes' answer, the underwriter can request the completion of a supplemental questionnaire at their discretion, usually based on findings in a report or medical examination on the applicant obtained during the underwriting process. When used, these questionnaires will be attached to and considered a part of the application, which is attached to and made a part of the policy.

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

Tobie Brink, Life Policy Analyst III
Product Development – Actuarial
One Moody Plaza, 14th Floor
Galveston, Texas 77550

e-mail: tobie.brink@ANICO.com
Phone: (409) 763-4661 x 4265
Fax: (409) 766-6933

Form ANL-ABP is the Application - Additional Beneficiary Page for Life Insurance.
This form may be used when multiple beneficiaries are named and additional space is needed or the applicant may have special instructions regarding the designation of a beneficiary(ies). In lieu of being restricted by the space provided on the application, this form may be completed and submitted with the application. When used, this form will be attached to and considered an extension of the application, and will become a part of the policy.

Additional information/supporting documentation included in this submission is as follows:

- Statement of Variability for the form
- Certificate of Readability
- Payment of the required filing fee in the amount of $1700.00 has been submitted via EFT
- Any requirement for a third party authorization has been bypassed, as this is not a third-party filing

Sincerely,

Tobie Brink

Tobie Brink
Life Policy Analyst III

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

May 6, 2011
MEMORANDUM OF VARIABLE MATERIAL FOR ANL-ABP

This memorandum was prepared for use with the above listed form (Additional Beneficiary Page) for American National Life Insurance Company of Texas. Variable material contained within the form denoted by use of brackets.

Variable Material

These forms contain the following permissible variable material:

Home Office Address
Mailing Office Address
Business (telephone number)
Business (fax number)

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

We certify to the following:

- The final form issued to the consumer will not contain brackets denoting variable text;
- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.

AMERICAN NATIONAL

AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS

May 6, 2011
MEMORANDUM OF VARIABLE MATERIAL FOR

- **ANL-MIL-AR**
- **ANL-FOR-AR**
- **ANL-DIA-AR**
- **ANL-EPI-AR**
- **ANL-SCU-AR**
- **ANL-RES-AR**
- **ANL-BLO-AR**
- **ANL-HBP-AR**
- **ANL-DRU-AR**
- **ANL-ALC-AR**
- **ANL-CUP-AR**
- **ANL-AVI-AR**
- **ANL-MOT-AR**
- **ANL-RAC-AR**
- **ANL-CPA-AR**
- **ANL-SPO-AR**
- **ANL-DIS-AR**
- **ANL-ABP**

This memorandum was prepared for use with the above listed questionnaires for American National Life Insurance Company of Texas. Variable material contained within the form denoted by use of brackets.

Variable Material

These forms contain the following permissible variable material:

Home Office Address
Mailing Office Address
Business (telephone number)
Business (fax number)

The above noted items, if changed, will be changed in accordance with department standards. It is understood that the items noted above may be changed without notice or prior approval.

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- Any variable text included in this Statement of Variability will be effective only for future issues;
- The use of variable text will be administered in a uniform and non-discriminatory manner, and will not result in unfair discrimination;
- Only text included in this Statement will be allowed to be used on the referenced forms received by consumers; and
- Any changes to variable or permissible ranges of values will be submitted for approval prior to implementation as required.